AND PLAN OF CORRECTION IDENTIFICATION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY  COMPLETED	
		155516	B. WING		05/11/2012	
NAME OF 1	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP CODE		
PARKVII	EW MEMORIAL HO	OSPITAL-CCC		RANDALLIA DR T WAYNE, IN 46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPRO	PRIATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
	This wisit was fo	or the Recertification and	F0000	This Plan of Correction		
			1 0000	constitutes our allegation of	of	
	State Licensure	Survey.		compliance.Please conside	er this	
	Common Datase N	Mari 0, 10, and 11, 2012		Plan of Correction to meet	the	
	Survey Dates: 1	May 9, 10, and 11, 2012		requirements of paper compliance versus an on s	ito	
	Facility Number	r: 001203		re-survey.	ite	
	Provider Number					
	AIM Number: 1	N/A				
	Survey Team:					
	Julie Wagoner, 1	RN-TC				
	Christine Fodre					
	Tim Long, RN					
	Census Bed Typ	ne:				
	SNF: 25					
	Total: 25					
	10441. 23					
	Census Payor T	vne:				
	Medicare: 12	Jr				
	Other: 13					
	Total: 25					
	23					
	Sample: 10					
		ies reflect state findings				
	cited in accorda	nce with 410 IAC 16.2.				
	Quality review of	completed on May 16,				
	2012, by Bev Fa	aulkner, RN				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

PRINTED: 05/25/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155516	(X2) MULTIPLE CC A. BUILDING B. WING	00				
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO ANDALLIA DR	DE			
PARKVIE	W MEMORIAL HO	SPITAL-CCC	FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		

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Event ID: JLIO11

Facility ID: 001203

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	IT OF DEFICIENCIES OF CORRECTION	DRRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING		00	(X3) DATE SURVEY COMPLETED 05/11/2012		
	ROVIDER OR SUPPLIER			2200 R	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DR WAYNE, IN 46805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
F0282 SS=D	0282 483.20(k)(3)(ii)		F02		Plan of Correction F 282 1.Resident #14 was unable t provide another specimen prio her discharge on 5-11-2012. 2.All other resident orders we reviewed and there were no ot residents on the unit that had orders for hematest stools. 3.Process was developed fo ordering, collecting and	r to ere her	06/08/2012
					communicating specimens needed for testing. (See document #1)  4.Educator will inservice staff regarding ordering, collect and communicating specimens needed for testing. (See document #2)  5.Quality Monitoring:  1.Monthly QI monitoring/collection form was developed (See document #3)  2.ADON will monitor all hematest stool orders each month.  3.QI monitoring results will be trended, reported, discusse and follow up initiated at QI meetings.  4.QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached,	data	
					less than six months of observation.	IIOI	

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Event ID: JLIO11

Facility ID: 001203

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPL	ETED
		155516	B. WIN			05/11/	2012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R			ANDALLIA DR		
PARKVIE	EW MEMORIAL HO	SPITAL-CCC			WAYNE, IN 46805		
					<u>.</u>		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	l `	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION DATE
IAU		·	F02		·		
		s record was reviewed	F02	82	Plan of Correction F 282 1.Resident #14 was unable t	to	06/08/2012
	_	m. Resident #14's			provide another specimen prior to		
	diagnoses includ	ed but were not limited			her discharge on 5-11-2012.	10	
	to diabetes, high	blood pressure, and			2.All other resident orders w	ere	
	multiple sclerosi	S.			reviewed and there were no of	ther	
					residents on the unit that had		
	A physician's ord	der, dated 5-5-2012 at			orders for hematest stools.	_	
		ted a stool for hemetest			<ul><li>3.Process was developed fo ordering, collecting and</li></ul>	I	
	l '	ool sample to see if blood			communicating specimens		
		b be performed 3 times.			needed for testing. (See		
	is present) was to	be performed 5 times.			document #1)		
	A	ADIindiantad			4.Educator will inservice		
		ADL summary indicated			staff regarding ordering, collect	-	
		d a medium incontinent			and communicating speciment needed for testing. (See	S	
		veen 8 p.m. and midnight.			document #2)		
		dication the stool was			5.Quality Monitoring:		
	hemetested.				1.Monthly QI monitoring/o	data	
					collection form was developed	l <b>.</b>	
	A review of the	ADL summary indicated			(See document #3)		
	Resident #14 had	d a large incontinent stool			2.ADON will monitor all hematest stool orders each		
	on 5-6 between r	noon and 6 p.m. There			month.		
	was no indication	n the stool was			3.QI monitoring results w	ill	
	hemetested.				be trended, reported, discusse	ed	
					and follow up initiated at QI		
	A review of the	ADL summary indicated			meetings.		
		d a medium incontinent			4.QI Team will determine when monitoring can be		
		veen 8 p.m. and midnight.			decreased to quarterly when		
		-			100% compliance is reached,	not	
	The stoot was ne	emetested negative.			less than six months of		
					observation.		
		ADL summary indicated					
		d a medium incontinent					
	stool on 5-7 betv	veen 8 p.m. and midnight.					
	There was no inc	lication the stool was					
	hemetested.						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155516			ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/11/2012
	PROVIDER OR SUPPLIE		2200 R	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DR	
PARKVI	EW MEMORIAL HO	OSPITAL-CCC	FORT V	WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Resident #14 ha 5-8 between 8 p was no indication hemetested.  In an interview of p.m., RN #1 indication hemetests because of possion the hemetest shown the formed state.  A policy and problem of the between the formed state.  A policy and problem of the between the formed state.  A policy and problem of the between the formed state.  A policy and problem of the between the b	on 5-10-2012 at 1:38 icated it was difficult to s on incontinent stool able contamination, but build have been obtained cool on the 8th.  becaute titled, "Occult lection (Hemoccult 7-2009 indicated d elect to complete testing the patient on diet and The policy did not er reason to refrain from			

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Event ID: JLIO11

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155516	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE : COMPL <b>05/11</b> /	ETED
	PROVIDER OR SUPPLIER		<u>'</u>	2200 RA	ADDRESS, CITY, STATE, ZIP CODE ANDALLIA DR VAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0371 SS=F	The facility must (1) Procure food considered satisf local authorities; (2) Store, prepar under sanitary of Based on observation facility failed to gap for the drains machine. This hall residents residents residents residents residents residents residents residents residents and the west hall lour Supervisor, emplice machine was 1 inch drainage pabout 6 inches from machine, curve decollection box. The was noted to be to the metal collection the west hall collection box. The was noted to be to the ice machine, gap located between the satisfactory and the west hall collection box. The was noted to be to the ice machine, gap located between the west hall collection box.	from sources approved or factory by Federal, State or and e, distribute and serve food onditions ation and interview, the ensure there was an air age part of the ice ad the potential to affect ding in the Continuing	F03	71	Plan of Correction F 0371 1. Employee #9 reviewed manufacturer installation instructions for the ice machine w installed according to the instructions; however there wa no documentation an air gap of back flow prevention valve w built into the drainage portion of the ice machine. 2. Employe #9 evaluated the ice machine 5 East and verified it did have a 1" air gap at the drain. 3. Employee #9 modified the cop tubing and drain box to accommodate the required 1" gap at the drainage portion of ice machine. 4. Quality Monitoring: The ice machine is been modified to meet the 1" air gap requirement at the dra This does not need to be reviewed via the monthly QI process since the repair is complete.	as as as as ar as as as as as as as ar as ar ar ar ar ar ar ar ar an	05/11/2012

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	OF CORRECTION  OF CORRECTION  155516	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE : COMPL <b>05/11</b> /	ETED	
	PROVIDER OR SUPPLIER EW MEMORIAL HOSPITAL-CCC	STREET ADDRESS, CITY, STATE, ZIP CODE  2200 RANDALLIA DR  FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	Interview with the Housekeeping Supervisor, Employee #8 and a Maintenance Worker, Employee #9 indicated they thought the ice machine had a "built in air gap" inside the machine.  However, interview, on 05/11/12 at 9:30 A.M., and review of the manufacturer's instructions for the ice machine indicated a "back flow" valve was built in to the water inlet part of the ice machine, but there was no documentation an air gap or back flow prevention valve was built into the drainage portion of the ice machine.  3.1-21(i)(2)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) D.			(X3) DATE :	SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G.	00	COMPL	ETED
		155516	B. WING	J	<del></del>	05/11/	2012
				REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8					
		SCRITAL CCC			NDALLIA DR		
PARKVIE	W MEMORIAL HO	SPITAL-CCC	I FC	JK I W	/AYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREF	FIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
F0441	483.65						
SS=D	INFECTION CO	NTROL, PREVENT					
	SPREAD, LINEN						
		establish and maintain an					
	•	Program designed to					
		anitary and comfortable					
	•	to help prevent the					
	development and	d transmission of disease					
	and infection.						
	(a) Infection Con	itrol Program					
	The facility must	establish an Infection					
	Control Program	under which it -					
	(1) Investigates, controls, and prevents						
	infections in the	facility;					
	(2) Decides wha	t procedures, such as					
	isolation, should	be applied to an individual					
	resident; and						
	(3) Maintains a r	ecord of incidents and					
	corrective action	s related to infections.					
		pread of Infection					
	` '	ection Control Program					
		a resident needs isolation to					
		ad of infection, the facility					
	must isolate the						
	· ,	nust prohibit employees with a					
		isease or infected skin					
		ect contact with residents or					
		ct contact will transmit the					
	disease.						
		nust require staff to wash their					
		n direct resident contact for					
		hing is indicated by accepted					
	professional prac	CIIC <del>C</del> .					
	(c) Linens						
		handle, store, process and					
		so as to prevent the spread					
	of infection.	so as to prevent the spread					
			F0441		Dian of Correction 5 444		06/08/2012
		review and interview, the	FU441		Plan of Correction F 441 1.Resident #20: An order wa		00/08/2012
	facility failed to	ensure 2 of 10 residents			i.Resident #20. An order wa	5	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIHLDI	a. Building 00		COMPLETED	
		155516	B. WING			05/11/2012	
	.n.o.v.n.n.n.a			STREET A	DDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIEF	· ·			ANDALLIA DR		
	EW MEMORIAL HO		F	FORT V	VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	OPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	1	ΓAG		DATE	
		d for tuberculin skin			obtained on 5-10-12 to repeat test. It was given on 5-10-12 a		
	_	skin tests read between			1316 and it was read on 5-13-		
	48-72 hours afte	r administration in a			at 0900.		
	sample of 10.				2.Resident # 4: Was		
	Findings include	::			discharged on 5-16-2012 3.All other resident Mantoux		
		s clinical record was			orders were reviewed and veri that reads were completed or		
		0/12 at 7:35 A.M. The			read date was correctly entere orders.	su III	
					4.Mantoux give/read process	s	
		the resident was admitted			was clarified. (See document #		
	to the facility on 5/1/12 and a tuberculin				5.A Mantoux Give/Read Foll		
		ministered on 5/1/12.			Up Form was developed and v	will	
		sident's record did not			be completed for every new	,	
	indicate the tube	rculin skin test was read			admission. (See document #5 6.Educator will inservice state		
	between 48-72 h	ours after			regarding Mantoux Give/Read		
	administration				Process. (See document #2)		
					7.Quality Monitoring:		
	An interview wit	th RN #5 on 5/10/12 at			1.Monthly QI monitoring/o		
		icated the tuberculin skin			collection will be monitored fro		
	· ·	tered on 5/1/12 in the			the Mantoux Give/Read Follov	V	
		rearm and was to have			Up form.  2.ADON will monitor all		
		/12. RN #5 indicated the			Mantoux give/read as they are		
					added to the form from the		
		est was not read on			admission nurse.		
	5/4/12.				3.QI monitoring results w		
					be trended, reported, discusse	ed	
		clinical record was			and follow up initiated at QI meetings.		
	reviewed on 5/1	1/12 at 10:00 A.M. The			4.QI Team will determine		
	record indicated	the resident was			when monitoring can be		
	administered a fi	irst step tuberculin skin			decreased to quarterly when		
		nd read on 3/31/12 and			100% compliance is reached,	not	
		r's induration. Resident #4			less than six months of		
		d step tuberculin skin test			observation.		
		record indicated the					
		rculin skin test was not					
	second step tube	icuim skin test was not	1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155516		A. BUILDING  B. WING			COMPLETED 05/11/2012		
		100010	B. WIN		PPPPG GYMY GW :	03/11/	2012
NAME OF P	ROVIDER OR SUPPLIER				ANDALLIA DD		
PARKVIE	EW MEMORIAL HO	SPITAL-CCC	2200 RANDALLIA DR FORT WAYNE, IN 46805				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
	read between 48-	1/2 nours.					
	<b>.</b>	Lat Direct CNL i					
		h the Director of Nursing					
		15 P.M., indicated the					
		step tuberculin test was					
		48-72 hours after					
	administration.						
	D : 04 0	nn in de t					
		cility policy titled					
		ssessment and Screening"					
	_	4/1994, last reviewed					
	1/2012, indicated	C					
	"1.C. A Mantoux	,					
	•	three months prior to					
	admission or adm	•					
	admission and re	ad at 48-72 hours."					
	The procedure in	dicated "II. A. The					
	baseline tubercul	in skin testing should					
	employ the two-s	step method. B. For					
	residents who has	ve not had a documented					
	negative tubercul	in skin test result during					
	the preceding 12	months, the baseline					
	tuberculin skin te	esting should employ the					
	two step method.	If the fist step in					
	negative, a secon	-					
	_	1 to 3 weeks after the					
	first test."						
	3.1-18(e)						
	\						

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	FORRECTION	IDENTIFICATION NUMBER:  155516	(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	MPLETED 11/2012
	ROVIDER OR SUPPLIE		STREET A 2200 RA FORT V	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155516	B. WING		05/11/2012		
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEI	₹		RANDALLIA DR			
PARKVIE	EW MEMORIAL HC	SPITAL-CCC	FORT WAYNE, IN 46805				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0502 SS=D	483.75(j)(1) PROVIDE/OBTA SVC-QUALITY/ The facility must services to mee: The facility is restimeliness of the Based on intervifacility failed to and hemetests as were obtained for reviewed for lab sample of 10 (Roffindings included Resident #14's respectively facility failed to and hemetests as were obtained for reviewed for lab sample of 10 (Roffindings included Resident #14's respectively facility for the facility failed for the facility failed to and hemetests as were obtained for reviewed for lab sample of 10 (Roffindings included Resident #14's respectively failed for the facility failed for t	AIN LABORATORY TIMELY the provide or obtain laboratory the needs of its residents. sponsible for the quality and eservices.  ew and record review, the ensure stool specimens or 1 of 8 residents test completion in a esident #14).  e:  ecord was reviewed  m. Resident #14's  led but were not limited  blood pressure, and  is.  der, dated 5-5-2012 at a ted a stool for hemetest tool sample is checked blood) was to be	F0502	Plan of Correction F502  1.Resident #14 was unable provide another specimen price her discharge on 5-11-2012.  2.All other resident orders we reviewed and there were no oresidents on the unit that had orders for hematest stools.  3.Process was developed for ordering, collecting and communicating specimens needed for testing. (See document #1)  4.Educator will inservice staff regarding ordering, collect and communicating specimen needed for testing. (See document #2)  5.Quality Monitoring:  1.Monthly QI monitoring/collection form was developed (See attachment #3)  2.ADON will monitor all hematest stool orders each month.  3.QI monitoring results we be trended, reported, discussed and follow up initiated at QI meetings.  4.QI Team will determine when monitoring can be decreased to quarterly when 100% compliance is reached,	objects of the control of the contro		
	A review of the	ADL summary indicated		less than six months of observation.			

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Facility ID: 001203

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M				X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		155516	B. WIN	G		05/11/	2012	
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE			
NAIVE OF FROVIDER OR SUFFLIER					ANDALLIA DR			
PARKVIEW MEMORIAL HOSPITAL-CCC			FORT WAYNE, IN 46805					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	SHOULD BE COMPLETION EAPPROPRIATE		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG DEFICIENCY)			DATE	
	Resident #14 had a large incontinent stool							
	on 5-6 between noon and 6 p.m. There							
	was no indication the stool was							
	hemetested.							
	A CHADI							
	A review of the ADL summary indicated							
		d a medium incontinent						
		veen 8 p.m. and midnight.						
	The stool was he	emetested negative.						
	Δ review of the	ADL summary indicated						
		d a medium incontinent						
		veen 8 p.m. and midnight.						
		lication the stool was						
	hemetested.							
	A review of the	ADL summary indicated						
		•						
	_	_						
		if the stool was						
	nemetested.							
	In an interview o	on 5-10-2012 at 1.38						
	_	· ·						
	on the formed su	ooi on the oth.						
	A policy and pro	cedure titled, "Occult						
		-						
	, ·							
	A review of the A Resident #14 had 5-8 between 8 p. was no indication hemetested.  In an interview of p.m., RN #1 indication hemetests because of possill the hemetest sho on the formed stored A policy and problem Blood Stool Coll Sensa)," dated 0' triplicate sample	on 5-10-2012 at 1:38 cated it was difficult to on incontinent stool ble contamination, but uld have been obtained						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155516	(X2) MULTIPLE CONSTR  A. BUILDING  B. WING	<u> </u>	X3) DATE SURVEY COMPLETED 05/11/2012			
NAME OF PROVIDER OR SUPPLIER PARKVIEW MEMORIAL HOSPITAL-CCC	STREET ADDRESS, CITY, STATE, ZIP CODE  2200 RANDALLIA DR  FORT WAYNE, IN 46805					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX CR TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
indicated samples were not to be collected if blood was visible. The policy did not indicate any other reason to refrain from completing the test.						
3.1-49(a)						

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